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**Subject:** DMA/AIFI01 - ALL FLEET VESSEL - DA11 - QITAPI-LP-35-2020(MAIB Extracted Accidents & Lessons to be Learnt).

***Ref: DMA-SAPID/IAFI01/99/C1098***
***Date: 2020.04.28***

*In The Name Of God*

*Good Day,*
*Dear Sir*

*Pl's find attached file* ***"QITAPI-LP-35-2020(MAIB Extracted Accidents & Lessons to be Learnt)"*** *which we are rcv'd from QITA for your kind attention and necessary precaution measures.*

***You are requested to confirm receipt, discuss the contents in the next consolidated meeting on board & keep a copy in the file DA-11 .***


***BEST REGARDS***
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# *Loss Prevention Circular QITAPI-LP-35-2020*
## *(MAIB Extracted Accidents & Lessons to be Learnt)*

**The following case studies have been extracted from the UK MAIB Safety Digest 1-2020:**

**►Case 1: Distracted by a Mobile Phone:**

*Narrative:*

A small cargo vessel was on sea passage and heading towards the coastline of the country of its next port of call. The OOW had taken over at 0200 and soon thereafter had started watching music videos on his mobile phone.

Between about 0230 and 0430 the vessel was slowly set off the planned track by the tidal stream in the area. This resulted in the vessel heading towards some outlying, uninhabited rocky islands, marked by a lighthouse. However, the risk of grounding had not been observed by the OOW.

The vessel was also proceeding towards an area where there was a voluntary reporting zone and a VTS area. Watch-keepers ashore noticed that the vessel was heading into danger, and made verbal warnings. However, the OOW did not respond in sufficient time to prevent grounding heavily on rocks.

The vessel was badly damaged by the accident and remained aground for several days until the cargo had been removed and sufficient tugs were available to haul it off the rocks.

The cargo vessel aground with the lighthouse visible in the background

QITA MC

## The Lessons

1. The accident happened primarily because the OOW was distracted from navigation by the use of a mobile phone. This is a hazard that must be guarded against by appropriate policies for the use of mobile phones at sea.

2. Fatigue was also a potential causal factor. It was the middle of the night and the OOW was alone and bored on a warm bridge. These were conditions that induced a high risk of falling asleep - and he might have done so from time to time.

   Combatting boredom and fatigue is about ensuring high levels of supervision and that safeguards, such as the bridge navigation watch alarm (BNWAS), are in use. In this case, the BNWAS was switched off and there were no other alarms in place to warn the OOW of the looming danger.

3. The shore authorities offered verbal warnings to the OOW that the vessel was heading into danger. These warnings were made in sufficient time for action to be taken to avoid the grounding. Bridge teams need to heed warnings from shore and establish exactly what is being reported and what action to take. In this case, the OOW was not comprehending the importance of the warnings being transmitted.

4. Passage planning is not limited to the intended track on the chart or in the ECDIS. A comprehensive passage plan should identify all the hazards ahead and determine the safest route. This should include identifying all navigation marks, lights and buoys, which should then be positively identified when observed and cross-checked with other navigational data to ensure accuracy of the passage. This vessel was approaching land and the rocky area where it ran aground was marked by a lighthouse, which would have been visual for a long time as the vessel approached. This was vital, visual navigational information that did not feature in the passage plan and was not subsequently utilised for navigational safety on board.

*The following can also be added to above points:*

1- *The use of mobile phones must be prohibited on the bridge, especially during coastal navigation & making a landfall. Using mobile phones for communication would certainly be a hazard & distraction to the person/s on the bridge, if the device is used for other purposes; it can be extremely affecting the situational awareness & lead to accidents.*
2- *Although the vessel has been of a small size with probably limited crew members on board, but still having a one man bridge while navigating in the proximity of land should be avoided so far as practicable.*
3- *Such precautions must be included in the Safety Management System & thus audited at appropriate intervals to make sure that such incorrect workmanship is not practiced on board vessel/s of the company.*

►**Case 2: Unplanned Inclination:**

*Narrative:*

Having completed loading, a container vessel was preparing to sail; the weather was fine with a gentle breeze. The chief officer decided to pump additional water into the starboard ballast tanks to level up tank volumes. This decision was based on his observation of port and starboard ballast tanks' contents from the tank capacity gauges on the operating panel. As the volume of water in the starboard tanks increased, the vessel started to list heavily to starboard. As the situation deteriorated, all the crew evacuated ashore.

After an assessment by the managing company, the master and the port authority, it was deemed safe for the crew to return on board and recover the situation by pumping out the ballast water from the starboard tanks. After the incident, manual soundings were taken, which showed that one of the port ballast tanks' gauges had been reading full when the tank was actually empty, and the fault was almost certainly an airlock in the gauge system.

Figure: The container vessel listing alongside

The Lessons

1. Ballasting operations should be planned, and maintaining an accurate picture of the state of the ballast system is critical for the safety and stability of the vessel.

2. Given the vessel was upright, it should not have made sense to add water to one side. When the vessel started to list, it would have been readily apparent that the ballasting was the problem, and this should have been stopped immediately.

3. Ballast system gauges are prone to inaccurate readings, so tanks should be sounded regularly with the levels recorded in the ballast logbook. This information can then be compared with gauges to check for discrepancies.